DC STEP: Healthy Infants and Mothers Program

Maternal Delivery and Hospital Abstraction Form

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THIS FORM IS TO BE COMPLETED BY THE RECORD ABSTRACTOR USING INFORMATION FROM THE MOTHER'S MEDICAL RECORD.

Site: _____ Today's Date: |__ __|__ __|__ __ __ __|
Site Code (If "Other," **SPECIFY**) mm dd yyyy

Mother's Medical Record Number*: _____

(*BE SURE TO BLACK OUT THE MEDICAL RECORD NUMBER BEFORE SENDING THE DATA FORM FOR DATA ENTRY. IF MULTIPLE BIRTHS, FILL OUT ONE MATERNAL DELIVERY AND HOSPITAL ABSTRACTION FORM BUT SEPARATE INFANT DELIVERY AND HOSPITALIZATION FORMS FOR EACH INFANT.)

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1. Medical conditions occurring during current pregnancy/delivery:
(CHECK APPROPRIATE BOX FOR EACH ITEM.)

a)	Eclampsia/preeclampsia	☐ 1 Yes	☐ 2 No	☐ –1 DNR
b)	Placental abruption	☐ 1 Yes	☐ 2 No	☐ -1 DNR
c)	Postpartum hemorrhage	☐ 1 Yes	☐ 2 No	☐ -1 DNR
d)	Ante partum hemorrhage	☐ 1 Yes	☐ 2 No	☐ -1 DNR
e)	Chorioamnionitis	☐ 1 Yes	☐ 2 No	☐ -1 DNR
f)	Other (Specify)	☐ 1 Yes	☐ 2 No	☐ -1 DNR

_____

2. a) Date admitted to hospital: |___ ___|___ ___|___ ___ ___ ___| ☐ -1 DNR
mm dd yyyy

b) Date discharged: |___ ___|___ ___|___ ___ ___ ___| ☐ -1 DNR
mm dd yyyy

c) Calculate length of stay and check below if ≥ 7 days:

1☐ Length of stay ≥ 7 days → **NOT ELIGIBLE, CONTINUE ABSTRACTION AND CONTACT DR. SUSAN BLAKE FOR FURTHER INSTRUCTION**

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3. Type of delivery: ☐ -1 DNR

Vaginal.....1
Primary C-section .....2 → **GO TO 3c**
Repeat C-section .....3 → **GO TO 3c**

3a. If vaginal, indicate presentation: ☐ -1 DNR
(CIRCLE ALL THAT APPLY.)

Cephalic (sunny-side up).....1
Breech.....2
Footling 3

3b. If vaginal, indicate intervention(s): ☐ -1 DNR
(CIRCLE ALL THAT APPLY.)

Suction/Vacuum 1
Forceps 2
None 3
Other **(SPECIFY)**.....4
→ **GO TO 4**

_____

3c. If Cesarean, give indication(s). ☐ -1 DNR
(CIRCLE ALL THAT APPLY.)

Acute Fetal Distress 1
Failure to progress 2
Placenta previa.....3
Placental abruption.....4
Repeat C-section.....5
Malpresentation.....6
Other **(SPECIFY)**.....7

_____

None.....8

4. Delivery/Post-delivery complications? ☐ -1 DNR
(CIRCLE ALL THAT APPLY.)

Infection **(SPECIFY)**..... 1
_____
Abruptio Placenta..... 2
Placenta Previa..... 3
Fetal Distress..... 4
Cord Prolapse..... 5
Proteinuria 6
Preeclampsia/Eclampsia..... 7
Amnionitis 8
Meconium/any..... 9
Meconium/noted to be "thick"..... 10
Ruptured Membrances > 24 hours 11
Chorioamnionitis 12
Delivery complications requiring resuscitation of mother..... 13
Serious postpartum maternal illness/health complications requiring lengthened hospitalization, surgery after delivery, or home IV antibiotics ... 14
Withdrawal from addictive substances requiring hospitalization or methadone treatment 15
Other **(SPECIFY)** 16
_____
None 17

5. Did mother have a fever accompanied by an infection either before, during, or after delivery?

☐ -1 DNR

Yes..... 1
No..... 2 → **SKIP TO Q.6**

5a. Indicate when fever occurred: ☐ -1 DNR
(CIRCLE ALL THAT APPLY.)

Prior to delivery 1
During delivery 2
After delivery 3

6. Were antibiotics given to mother either before, during, or after delivery?

☐ -1 DNR

Yes..... 1
No..... 2→ **SKIP TO Q.7**

6a. Indicate when antibiotics were given: ☐ -1 DNR
(CIRCLE ALL THAT APPLY.)

Prior to delivery 1
During delivery 2
After delivery 3

7. Urine test for drug use during hospitalization? ☐ -1 DNR

Yes 1
No ..... 2 → **GO TO Q.8**

7a. Urine test results: ☐ -1 DNR

Positive 1
Negative ..... 2→ **GO TO Q.8**

7b. If POSITIVE in question 10a, for which drugs did the woman test positive?

_____ ☐ -1 DNR
_____
_____
_____

8. In general, how easy or difficult was it to decipher the information contained in the medical record(s)?

Very easy 1
Somewhat easy 2
Some information easy/some difficult 3
Somewhat difficult 4
Very difficult 5

9. Describe any special problems in completing the abstraction:

_____
_____
_____
_____
_____

ABSTRACTED BY: _____ |__ __|__ __|__ __ __ __|
Abstractor Code mm dd yyyy

EDITED BY: _____ |__ __|__ __|__ __ __ __|
mm dd yyyy

MATERNAL ABSTRACTION SUMMARY SHEET:

1. Did the mother experience any of the following exclusionary criteria? **CIRCLE ALL THAT APPLY.**

a) Multiple birth	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
b) No PNC or 1st PNC visit at $\geq$ 28 weeks	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
c) Delivery complications requiring hospital stay of $\geq$ 7 days	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
d) Withdrawal from addictive substance requiring hospitalization or methadone treatment	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
e) Psychiatric illness (may need to refer to Maternal Postpartum Clinic Abstraction Form)	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
f) Loss custody of infant	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR

2. Other maternal health conditions that may need review for decision to exclude:

a) Delivery complications requiring resuscitation of mother	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
b) Serious postpartum maternal illness/health complications requiring lengthened hospitalization, surgery after delivery, or home IV antibiotics	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR
c) Other (SPECIFY)	□ $_1$ Yes	□ $_2$ No	□ $_{-1}$ DNR

____

IF YES TO ANY OF ABOVE→ CONTACT DR. SUSAN BLAKE AND DR. DANA BEST FOR POSSIBLE EXCLUSION FROM STUDY.

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FINAL MATERNAL DISPOSITION:

ELIGIBLE □ $_1$ INELIGIBLE □ $_2$

SIGNATURE: ____

DATE OF DECISION: ______________________________________